INTERNATIONAL BALLET ACADEMY

ARTISTIC DIRECTOR | VERA ALTUNINA

Medical Information Form

Student Name: ___________________________________ **Date of Birth:**_____________

Parent or Guardian (If under 18): ____

Home Telephone: (___)____________________

Work Telephone: (___) ____________________

Cell phone: (___) ________________________

Physician Name: ____

Location: ____

Telephone: (_____) __________________________________

Please circle the appropriate answer and fill in the necessary blanks.

Is/Has/Does the student:

1. Medically limited or have restricted physical activity? YES NO

   If yes, for what reason?____

2. Had recent major surgery or broken bones? YES NO

   If yes, when?_______________ For what? _________________________________

3. Suffer from allergies or asthma? YES NO

   If yes, which? ____

   What substances cause reactions? ____________________________________

4. Receives routine or emergency medication for allergies or asthma? YES NO

   If yes, is the medication kept with the individual and is it self-administered? YES NO

5. Take any other routine medication? YES NO

   If yes, what medication? ____

6. Please indicate any other learning/physical/emotional/ behavioral information of which you feel we should be aware.

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Emergency Medical Authorization: Signature below authorizes a physician or EMT to provide emergency care as deemed necessary to ensure proper care of an injury.

Signed: ____ **Date**: ______________________________

Rev: 7/2/15